Legislative Testimony
Public Health Committee
HB5541 AAC Services Provided by Dental Professionals and Certification for Advanced Dental Hygiene Practitioner
Wednesday, March 21st, 2012
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Senator Gerratana, Representative Ritter and Members of the Public Health Committee: My name is Allen Hindin. I am a privately practicing general dentist from Danbury and Director of Dental Services for United Cerebral Palsy of The Hudson Valley, in Brewster, NY, where I have served patients in our safety net clinical facility for the past 15 years. I have provided clinical services ranging from implants and bridges to the simplest of treatments and continue to do so full time. I have served as a staff dentist at two Danbury area convalescent homes for more than 25 years, been a member of the Danbury School Based Health Center Board and currently am a member of its school based dentistry advisory group. From 1979 to 1996, I was full time director at Danbury Hospital, where its general practice dental residents and staff dentists managed over 20,000 patient visits a year, including in-patients and those admitted for treatment under general anesthesia. From 1975-80, I was project dentist for The Model School Health Program here in Hartford. I served three years a Captain the US ARMY Dental Corps, where I also completed residency training in general dentistry.

I received an MPH from NY Medical College in May, 2003.

My clinical experiences include working with Head Start and other children, migrants from farms and vineyards along the Hudson Valley, "Husky," adult Medicaid populations in NY and CT as well as several Missions of Mercy. I have, for more than 30 years, been excited by the potentials within school based dental care.

While serving in the US Army (1971-74). I was exposed to expanded function dental auxiliaries (EFDA), a stark contrast with my dental school experiences, where solo, unassisted practice was what we were taught. I became enamored with the ability to accomplish more, the use of goals and objectives to serve patient needs, the role of team leader. Upon meeting the creative group of Majors and Lt. Colonels, who were driving force behind it all, my curiosity relating to dental team potentials continued to grow, along with an interest in public health combined with clinical practice.

My first encounter with dental therapists took place in August, 1974, the result of a serendipitous encounter with the director of The New Cross School for Dental Auxiliaries a training site for dental therapists, just outside of London, U.K. Curiosity took over from there. A little more than a year later, a friend on faculty at Tufts encouraged me to visit The Forsyth Center, where research in expanding the role of dental hygienists was then underway. As Model School Health Program dentist, at the Mary Hooker School in Hartford (1975-80), I had the opportunity, in 1979, to site visit the Saskatchewan Dental Nurse (NZ therapist type) training site and school settings in which they practiced. More recently, I have been to Alaska and visited the Dental Health Aide Therapist training site in Anchorage. I have attended The Pew Charitable Trust and The Kellogg Foundation workshops and meetings regarding dental therapist potentials, most recently in September and November.

What I have learned from my studies regarding dental therapists, commonplace in New Zealand, Australia, parts of Canada, The UK, soon Holland and many other countries, is that they are quite different from the proposed Advanced Dental Hygiene Practitioner. Successes reported by dental therapist based programs have been attributed to low cost education requiring approximately two years, a focus upon provision of basic clinical and preventive services, supervision by dentist team leaders, recruitment from within target populations, with language, community awareness and cultural competency often mentioned as foundational. In addition, dental therapists do not perform prosthetic, orthodontic or other such complex services.

Dental hygienists are to dental therapists as nurse practitioners are to physician assistants. Hygienists focus on periodontal disease and caries detection, with a focus on prevention. Dental therapists have more of a clinical role, with a focus on five or so basic dental treatments needed by a high percentage of traditionally under-served populations. They complement one another in dentist led teams, such as those currently serving Native Alaskans. While they have some overlapping skill sets and important roles, one does not subsume the other, as seems to be the objective of HB 5541.

There is much that we do not know, here in Connecticut and America, about models incorporating therapists and much that we need to learn. How much or how little time is needed to train them, at what costs, and who benefits? **The proposed model in this legislation requires six years of higher education, at a cost many times that associated with the traditional model dental therapist**. Do we need six years to produce them, or does the two year-four month Alaskan/New Zealand model suffice? It is important to note that the NZ model, the original template, is over 91 years old and has often been replicated. We can surely learn from it. Is licensure necessary for regulatory purposes or is certification sufficient especially if a two year model is adequate and that individual is supervised by a licensed dentist? How closely do therapists need to be supervised? Are therapist based delivery models more effective if recruited from the communities they will work in?

I support **studying** dental therapists being added to dentist led teams, as a potential means to increase and improve access to care among poor and near poor populations. These types of models have even greater potentials in school based settings. Kindly note that I use the word "potentials." **I believe that pilot projects exploring these potentials must be designed, implemented and properly studied before requesting legislation enabling this class of dentist extenders.**

ADHP is like no other dental therapist model. It is the only model requiring six years, a bachelors and a masters degree, a career pathway likely to cost in excess of $250-300,000 in a private university setting. It is by far the most costly model, in terms of time and money, and will effectively limit access by the poor or near poor who might otherwise choose this career path. We are all aware of the impact of "degree creep" and its impact upon health care costs. What impact will such high entry costs have on community care providers, who would seek to employ dental therapists, only to find that expected salaries are prohibitive? Why a bachelors and a masters degree, rather than a two year certificate, which could be obtained from far less expensive community colleges, the more common way for dental hygienists to be educated in America today? I question and challenge the need to entrap within legislation academic requirements which benefit universities or four year colleges at the expense of community colleges, which might serve much more effectively to produce effective dental therapists. I question the need for a licensing infrastructure, with associated government costs, when certification may be all that is needed for a team role under a licensed dentist, who is accountable for the actions of team members.

Supporters of ADHP have not done the research necessary before seeking enabling legislation from the CGA. It is wrong of them to bypass commonly accepted research methodology, wrong to ignore valid alternatives and wrong to build and formalize programs without laying appropriate foundations. It is wrong to create legislation which will require only the most expensive of all possible pathways to dental therapist training, essentially sucking the air out of potential creativity in the public interest. If we dentists, in public health settings, can only face ever more expensive options, how can we attempt to meet the basic needs of increasing numbers of poor and near poor, while at the same time facing less funding? There is a very good reason why The Kellogg Foundation has embarked upon a mission to introduce the two year therapist model to America and why it has not embraced ADHP.
Proponents of ADHP have had the legal authority (GS 379, Sec 20-123, d-5) to undertake controlled workforce investigations within accredited schools of hygiene since 1971. **There is no reason why ADHP has not been or could not be piloted and a proper study or studies conducted. I strongly urge the Public Health Committee to demand such investigations prior to any legislative actions**.

The public, especially the dentally under served, will not benefit significantly by enacting legislation serving the interests of hygienists and educational institutions. ADHP, at this time an unknown, ought to

be compared to existing dental therapist models. These models should be investigated as to how and why they will benefit the citizens of Connecticut. Such comparison will undoubtedly provide basis for a more rational discussion than the Public Health Committee is likely to have today. I urge further study of ADHP, the MN and Alaskan dental therapist models and ask only that the Public Health Committee go on record as encouraging appropriate investigation regarding dental therapists.

EFDAs have no need for licenses, clinical exams or malpractice insurance, as evidenced by the experiences in many states over the past 35 years. Historically, in the civilian sector, it has been a one year add-on to typical one year dental assisting programs, followed by passage of the Dental Assisting National Board (DANB) examination being all that is needed for certification.. This training takes several months in the US military, where it is more concentrated. Those who have served as an EFDA in the US military, under the occupational specialty of EFDA, for at least two years, with an honorable discharge, and passage of the DANB examination should be offered an acceptable pathway for acceptance in Connecticut. These veterans may prove to be an important source of new workforce and ought not to be overlooked.

Certification of EFDA skills is sufficient for public protection (NEW Sec. 2. Section 20- 112a). Licensed dentists are already required to employ staff with appropriate credentials, such as dental assistants with radiology certification and dental hygienists, before allowing them to provide care for patients. Assistants and hygienists are not required to carry malpractice insurance, since their actions are the responsibility of their employers. States which have enabled EFDA have not experienced higher malpractice rates for offices which employ them. Requiring malpractice insurance of EFDAs will do nothing but add only to costs. Additionally, there is no need for EFDAs to be registered or otherwise tied into the Department of Public Health regulatory activities any more than certified dental assistants are. EFDAs perform only reversible procedures, the placing and finishing of restorative materials and fabrication of temporaries. The dentist remains accountable to patients and DPH for what might be delegated to EFDAs.
As a funny aside, does any legislation limit the number of dental assistants or dental hygienists a dentist may employ? Why can only two EFDAs be employed by a dentist? There are several scenarios I can envision, in which more than two could be desirable. Where did this limit come from?

Atraumatic Temporary Restorations (ATR) is mentioned in New Sec. 6. It appears to be a skill limited to ADHP. It should not be so restricted and ought to be obtainable by any CT licensed dental hygienist. It is quite effective at stopping decay, easy to teach and remarkably simple to perform. ATR has been used successfully worldwide and has been particularly beneficial to poor and near poor children. Courses in its use could be provided in community settings, require little time and expense. Dental and hygiene associations, our state hygiene and dental schools, along with teaching hospitals providing dental residencies could be excellent means by which many hygienists could acquire ATR skills quickly and employ them in places such as Head Start and other school environments, even in patients residences. Please do not miss this opportunity to make a real difference.

I would also like to express my sincere disappointment with the process enacted last year, designed to reduce or eliminate many of the problems I see in HB 5441. If the DPH report on scope of practice issues, mandated by HB 5649 and diligently complied with by many in this room today, had any impact upon the bill here being testified to, I see no evidence of it what so ever, There are really three bills in HB 5541. This leads to confusion and loss of some very good and needed legislation, which can readily dissected from HB 5541.I urge this committee to do just that.
Please feel free to contact me if you have any questions.

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